Republic of Zambia
Ministry of Health

Addressing Gender-Based Constraints to Health Service Uptake

Findings of a Study to Inform Health Planning

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Cover Photo: Family members escort newborn twins home from a clinic in Lundazi District.

Photo credit: Thandizani Community Based HIV/AIDS Care and Support

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Foreword

The study was carried out as part of the Ministry of Health (MOH) mandate to identify barriers that affect access, demand and utilisation of health services in Zambia.

Key approaches to addressing the gender-based constraints that inhibit the uptake of health services in Zambia that were identified in the study include: Promoting women's health decision-making power; promoting positive treatment-seeking behaviours amongst men; promoting respectful and less judgmental attitudes amongst health care workers and promoting gender-friendly clinics, which include making efforts to create a gender balance amongst health workers.

The study focuses on the best practice approaches that could be implemented within the Ministry to constructively confront and eliminate gender-based constraints to utilisation of health services. It further provides health planners at the provincial and district levels with a better understanding of how gender can influence health service uptake.

According to the 2006-2010 National Health Strategic Plan, the gender-based constraints in accessing health care, which ultimately impact on health outcomes, have not been given due attention.

Through the 2011 – 2015 National Health Strategic Plan, the Government of the Republic of Zambia is committed to ensuring that gender is not only integrated in various programmes but also mainstreamed in all its ministries and departments. As can be seen in the National Health Policy, the government has committed to ensure gender responsiveness in management and delivery of health services at all levels of service delivery.

Hon Dr. Joseph Kasonde, MP
MINISTER OF HEALTH

Contents

List of Acronyms

ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BCC	Behaviour Change Communication
DCMO	District Community Medical Office
DHS	Demographic and Health Survey
EmONC	Emergency Obstetric and Newborn Care
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
NHSP	National Health Strategic Plan
PMO	Provincial Medical Office
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
ZISSP	Zambia Integrated Systems Strengthening Programme

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Davy Chikamata
Permanent Secretary
MINISTRY OF HEALTH

1. Introduction

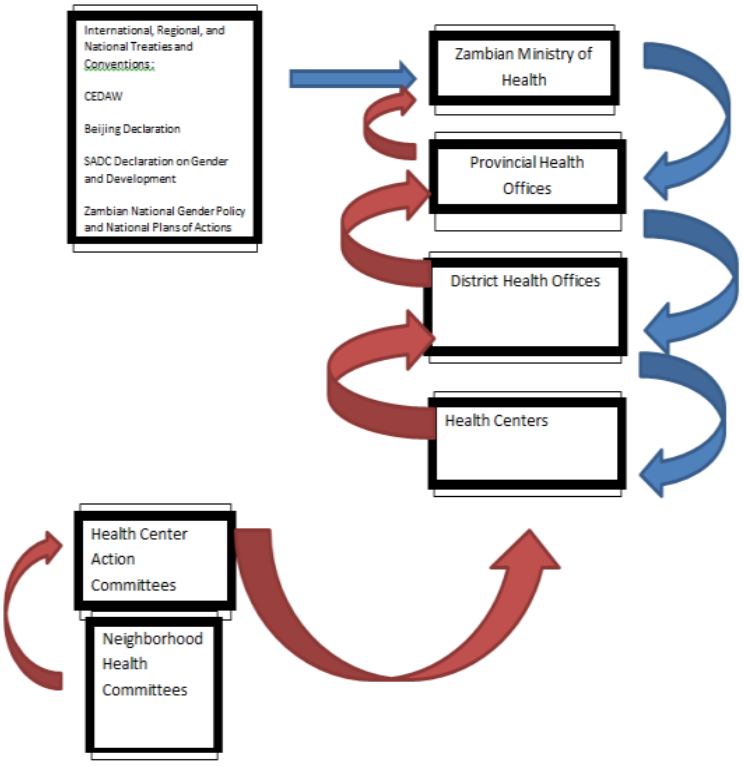
Zambia's 2006-2010 National Health Strategic Plan (NHSP) observed that the "issue of gender differences in accessing health care and the impact on health outcomes does not seem to have received the attention it deserves." It continues by noting that there is a "lack of conceptual understanding of gender" and "limited technical expertise and lack of appreciation of linkages between gender and health" (NHSP, 2011:19, henceforth referred to as NHSP 2006-2010).

Experience in other countries shows that there is often a gap in the national and subnational understanding of the importance of addressing gender considerations in health. This gap can lead to a situation where gender-relevant policies and approaches promulgated on the national level are often incomplete or inconsistently implemented on the subnational level.

This study is an attempt to address this gap. It is designed to highlight the linkages between socially constructed notions of gender and the ability and desire of men and women to access and use public health services. It seeks to locate the gender-based constraints that inhibit the uptake of health services and highlight current best practices to address them. In so doing, this study seeks to motivate and inspire health planners at Provincial Medical Offices (PMOs) and District Community Medical Offices (DCMOs) to provide the leadership necessary to effectively implement Ministry of Health (MOH) gender-related directives from the top down.

Whilst enabling health planners to effectively implement top-down directives is important, it is equally important that health planners on the subnational levels are able to identify the gender-based constraints that occur on the community level and inspire action from the bottom up, a direction that the NHSP 2011-2015 emphasises (NHSP, 2011). The MOH, through its NHSP, has implemented a bottom-up health planning structure in an effort to create a health system that is better able to respond to community needs and to create community responsive health services that are used and appreciated. The health planning structure is depicted in Figure 1.

Figure 1: The Health Planning Structure



PMOs and DCMOs play a pivotal role in ensuring the success of the health planning process to achieve this goal. On one level, these health leaders are the "eyes and ears" of the MOH. They are positioned close to the communities and can therefore identify gender-related issues that occur on the provincial and district levels. Therefore, another objective of this study is to help PMO and DCMO health planners hone their ability to recognise gender issues when they emerge at the community level, and to motivate health planners to bring these issues into the MOH health planning discussions that occur at the national level. It will also be important for health planners to present some best practice approaches to respond to gender issues that have been effective in addressing these issues in other parts of the world, so Zambian health planners can adapt them as they see fit within the Zambian context.

PMO and DCMO health planners can also positively influence the health planning process itself. Because they have the mandate to make the process more inclusive and participatory, they play a crucial role in ensuring that more women meaningfully participate in Neighbourhood Health Committees and Health Centre Advisory Committees. They can also make changes to the health planning process to encourage more women to serve in leadership positions within these committees. Furthermore, the health planners at the PMOs and DCMOs have the capacity to develop creative ways to open up the health planning process to allow more discussion of gender-based health issues and consequences and to develop ways to address them at the community, district and provincial level.

Given their pivotal role in promoting a more gender-sensitive health planning process, this study seeks to make the case for health planners to proactively engage more women in the local health planning process, and to create space within the process for citizens and health planners to collectively discuss and analyse gender considerations that have heretofore been viewed as outside the purview of health planning.

2. Background

2.1 Bringing gender into the equation

Gender has a profound effect on the uptake of public sector health interventions. Gender endows men and women with different access to resources. It assigns them to different social roles. It accords them different decision-making power and it shapes the choices available to them as they pursue their health-seeking goals. All of these dynamics influence the kinds of health services men and women want, how men and women use health services and their experience within the health facility. One's gender has an enormous impact on how one is treated with the health facility and the quality of care one receives.[1] It can impact the type of treatment prescribed and one's ability to adhere to it. All this influences the prospects of the health system to improve health outcomes and people's willingness to use modern health services in the future.

Due to the fact that gender is so embedded in Zambian culture, its impact on health outcomes and health service uptake often goes unnoticed. Rarely do health planners stop to investigate the impact that allowing male clients to jump the queue when seeking treatment might have on their female counterparts attending similar services. Discussions of the negative health outcomes that result from delayed treatment as health care providers try to locate the male head of household in order to make a health decision do not usually make their way into the facility quality improvement processes. And whilst many health care providers on the facility level may acknowledge that a sole young man may feel uncomfortable in a waiting room filled with women and children, they are not likely to consider it a problem that is within the purview of the health system to correct.

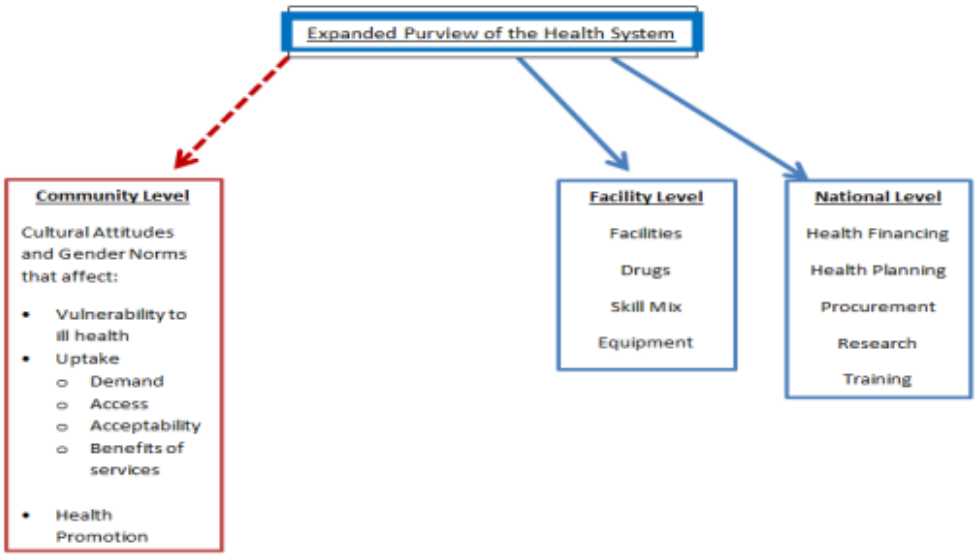
The failure to take gender into consideration in the design and implementation of health initiatives often leads to the creation of health services people may not feel they need, or worse, to services that people feel they need and want, but do not use. The limited uptake of health services not only negatively impacts the health status of all citizens; it is also an enormous waste of precious public resources.

Because we assume gender relations to be an intrinsic part of our world, we rarely notice the negative outcomes that result from the way gender is constructed. Our cultural blinders prevent us from seeing these outcomes as "problems" because it does not occur to us that things could be otherwise. We therefore tend to dismiss these outcomes as natural and unchanging hazards of culture, rather than problems that we could do something about. It is usually only when these cultural norms are brought under the purview of our investigation that we are forced to look critically at elements within our own culture.

Gender norms have also escaped the notice of health planners because cultural and gender norms have been outside what was traditionally considered the mandate of the health system to address. Over the past four decades, this view has started to change. The HIV pandemic and persistently low uptake of family planning services have brought about a new awareness of the need to address gender norms in efforts to promote service uptake (United Nations General Assembly, 2013). This new awareness has prompted efforts to expand the mandate of the health system so that it can better address the social and cultural norms that exist outside the health centre. These efforts have brought "gender" under the purview of investigation and made it a relevant "problem" to be addressed. More recent reforms have focused on promoting community-level activities designed to help communities challenge and address the gender and cultural norms that make men and women vulnerable to ill health as well as those norms that inhibit the demand for and uptake of health services. A model of the expanded purview of the health system is provided in Figure 2.

[1] See for example: Bösner et al. (2011); European Institute of Women's Health (2012); Gomez, Haas, de Mestral et al. (2012); Borkhoff et al. (2008); and Beery (1995). For a good discussion about how nurses can respond to gender bias in treatment see: Alspach (2012).

Figure 2: Expanded Purview of the Health System[2]



2.2 Analytical Framework

The uptake of public health interventions is the result of a complex interplay of many factors. Many of these factors include the demographic characteristics of patients, patients' awareness of symptoms, their knowledge of what services are available and the availability of alternative forms of medical treatment. What people anticipate they will encounter in the health centre and the quality of care they anticipate to receive can also influence their willingness to use public health services (World Health Organisation, 1995).

Kuoeger (1983) and others frame the uptake of health services as an expression of opportunity cost. According to these models, people weigh the perceived need for services (demand) and the benefits they think they will get from treatment against the costs they expect to incur in using health services. (See Figure 3.)

Figure 3: The Uptake of Health Services as an Opportunity Cost Model

Source: Adapted from Kuoeger (1983)

[2] Adapted from the National Community Health Worker Strategic Plan

Low demand for services exists when people do not feel the need to use the health services that are available. That is, when people say the health services offered are not services they need or want, then it is presumed that there is a low demand for health services (World Health Organisation, 1995). The demand for health services therefore has to do with people's knowledge of health and ill health and their knowledge of the types of services available.

However, as the same observers note (World Health Organisation, 1995), when services exist that people say they do want but do not use, then it usually signals that there is a problem with the way that health services are being offered. According to these observers, when people do not use services they say they want, then it usually indicates that either people have a problem accessing available facilities, or there is something about the way health services are offered that people do not find acceptable. Thus, in cases where the demand for services has been established, low levels of service uptake usually indicate that people anticipate they will encounter specific challenges or "costs" in getting to and using health services.

According to the above model, the costs of using health services are weighed against the benefits that people feel will result from using services. The perceived benefits of using health services therefore have to do with improved health. People are therefore more likely to incur the costs of getting to and using health services if they perceive using health services will result in improved health outcomes.

This study uses the above framework to identify and analyse how gender impacts the uptake of public health interventions in Zambia. It assumes the uptake of health services to be a reflection of the demand for services, the accessibility and the acceptability of services and the benefits people feel will result from using services. It demonstrates how gender norms influence the demand for health services and shows that men and women encounter different challenges and obstacles in using services, which result in different costs. It also discusses how gender norms impact the quality of care patients receive which can have a determinant effect on the perceived benefits in using public health interventions and their willingness to use public health services in the future.

3. Addressing Root Causes of Gender-based Constraints to Health Service Uptake

3.1 Purpose

This study is designed for use by health planners at the PMO and DCMO levels. It seeks to help health planners appreciate the need to see gender-based constraints that limit the uptake of health services as "real problems" that need to be addressed if the MOH is to achieve the goals set forth in its 2011-2015 NHSP. By demonstrating the negative impact that gender-based constraints have on health service uptake, and by explaining the rationale behind approaches to address these constraints, this study seeks to inspire and motivate health planners to be gender responsive in their design, planning and delivery of health services at all levels.

3.2 Methodology

The first phase of this research consisted of a desk review of health and anthropological literature to provide a snapshot of how gender is constructed in Zambia and how it relates to men and women's treatment-seeking behaviour. This desk research was followed by a series of focus group discussions (FGDs) held with men and women and adolescents in Nakonde and Kafue districts.

There were two sets of FGDs with male adolescents and two with female adolescents for a total of four FGDs with adolescents. There were two sets of FGDs with men and women, and there was one mixed group meeting with both men and women at Mwenzo Rural Health Centre in Nakonde District. The FGDs were conducted in December 2012 by the consultant, assisted by officers from the Zambia Integrated Systems Strengthening Program (ZISSP). The FGDs were intended to ground test the findings of the desk research.

In the FGDs, a series of open-ended questions were asked. Questions probed the reasons why participants did or did not use services and sought to identify conditions under which participants would be more likely to use services. The FGDs also sought to shed light on the environment in which men and women pursued their treatment-seeking goals and to identify obstacles men and women encountered at different stages in seeking treatment.

3.3 Limitations of the study

There are a number of limitations of this study that are important to consider. Firstly, the way gender impacts treatment-seeking behaviour depends on how it (gender) is constructed in any given society and how it functions in tandem with other social markers such as age, location, education and wealth. In Zambia, there are so many variations amongst different tribes and communities as well as clear distinctions between levels of education and location (rural/urban)[3]. The sample size of this study was very small and FGDs were conducted in only two districts. Therefore, caution should be exercised when making any generalisations or extrapolating the findings to the country as a whole.

As the purpose of the study was to identify gender-based constraints that inhibit the uptake of services for purposes of planning, the analysis is limited to gender-related obstacles that are within the health system's manageable interests to correct. The analysis therefore did not dwell on the macro-level determinants to health promotion that are outside MOH's purview. For example, whilst numerous studies have shown that girls' education is the most critical determinant for health service use (Ensor

[3] For example, 83% of urban women have deliveries assisted by a skilled birth attendant whereas rural women have 31%. (Global Health Initiative in Zambia.)

and Cooper, 2004), it is not within the MOH's mandate to systematically advance girls' education. Instead, the analysis focused on identifying ways in which the health system can use to address the gender-based constraints that are within the Ministry's mandate.

Similarly, it should also be noted that whilst gender influences all sorts of health decisions, this analysis focused on how gender impacts access to, demand for and use of high-impact services and priority areas that have been identified with the NHSP and are within ZISSP's mandate. These include family planning, maternal, neonatal and child health and nutrition, adolescent health, malaria, clinical care, quality improvement, emergency obstetric and newborn care (EmONC), human resources for health and health on the community level.

4. Findings: How Gender Affects the Uptake of Public Health Services

Section 4.0 explores how differential access to resources and decision-making power creates challenges and obstacles for men and women when they attempt to use health services. The obstacles to health uptake that occur because of the way gender is constructed are referred to as "gender-based constraints." Using the framework presented in Figure 3, this section of the report highlights where and how gender-based constraints negatively impact the demand for health services. It also identifies where gender creates different obstacles and costs for men and women as they seek health services.

It is presumed that people are more likely to withstand and overcome these obstacles if they think there will be benefits in them doing so. Therefore, if the health system is going to improve uptake of services offered, it's not enough to make health services more accessible and acceptable, but also needs to show people in real terms that the benefits of using health services will outweigh any costs they are likely to incur. However, Section 4.0 illustrates how social constructions of gender can compromise the ability of the health system to deliver health benefits. The section seeks to show that rather than being "natural" and the accepted order of things, presumptions about gender and the way men and women are valued within the health facility have real consequences on health outcomes and health service uptake and therefore can and should be addressed in efforts to improve the quality of health services.

Gender accords men and women different knowledge, skills, opportunities to access resources and different decision-making power. Section 4.0 demonstrates how these gender differentials affect the demand for health services and create different obstacles and challenges (or gender-based constraints) that men and women encounter as they pursue their treatment-seeking goals.

Using as a guide Figure 3, the model drawn from *The Uptake of Health Services as an Opportunity Cost Model* (Kuoeger, 1983), the part of this section of the report (4.1) focuses on ways that gender limits the demand for health services. The second section (4.2) discusses gender-related obstacles that men and women face when trying to access health services. This is followed by a discussion of gender-based obstacles people encounter in health facilities and in using health services. As the Kuoeger-inspired model points out, the benefits people think they can get from using the health system have a lot to do with their willingness to use the system. Therefore, this section also looks at how assumptions regarding gender both in and outside the health system can affect the health outcomes and the benefits people think they will get from using these services (4.3).

4.1 How gender shapes the demand for health services

Kuoeger (1983) points out, that the demand for treatment depends on people's awareness of their symptoms and the types of services that are provided through the health system. It depends on whether or not people feel the services provided are those that they need. The FGDs with both men and women revealed that there are significant gender differences in the way in which men and women respond to symptoms of ill health and their willingness to use public health services once they have identified these symptoms.

4.1.1 Awareness of danger signs of illness and available health services

The findings of the FGDs confirmed the notion presented in much of the health literature that there is higher demand for health services amongst women than amongst men. Many of the participants noted that women tend to be more aware of health issues in general. Both men and women said that women are more attuned to noticing ill health because it is "in women's nature" to be sensitive and caring. However, respondents also attributed women's awareness to the fact that women, as mothers, are

responsible for the wellbeing of children and for caring for the sick, and therefore are "closer" to the sick.

Respondents also noted that as women play the role of promoters of health within the family, they are the targets of public health information campaigns. As a result, respondents explained that women tend to know more about the symptoms of illness and relate those symptoms to ill health. It is interesting to note that in both adult FGDs, participants claimed that because women were more knowledgeable of symptoms of serious health concerns (e.g., malaria), they were more likely to associate such symptoms with disease (e.g., such as associating a headache with malaria) and therefore would be more likely to go to the health centre earlier for diagnosis. On the contrary, men lack this information and therefore are less likely to seek medical attention despite having symptoms indicating serious illness.

Participants also noted that women tend to have a better idea of the kinds of services that are offered through the public health system and are more inclined to use public health services than are men. Both women and men noted that men show a clear preference to use traditional healers or to self-treat rather than go to a health centre – a phenomenon also noted in the literature and evidenced by findings of the 2007 Demographic and Health Survey (DHS) (Central Statistical Office et al., 2009; henceforth referred to as DHS 2007).

Thus, according to the FGD participants, requests to go to a health centre are usually initiated by women. Respondents noted that whilst it is men who are asked for permission to go to a health centre and who have the final say in the matter, woman would instigate the request to go. Men, according to the participants, are not likely to suggest going to a public health centre. However, whilst it was well acknowledged within the FGDs that women have more desire to use public health services, their ability to act on that demand is compromised by their gender.

4.1.2 Traditional male gender norms discourage treatment seeking

Traditional gender norms that equate men's illness with weakness and portray men's treatment-seeking behaviour as indulgent and "unmanly" have been noted as a significant gender-based constraint to the uptake of health services in many parts of the world (Barker, 2005). From an early age, boys are taught that they have to be tough or strong; they cannot cry or show weakness. This gender norm of male behaviour translates into the perception that admitting sickness is a sign of weakness in a man. It also leads to the perception that seeking treatment for illness would be considered indulgent behaviour for a man.

As a result of these gender norms, men are conditioned to ignore or deny their ill health when it first occurs. Men in both the FGDs reported that they were raised not to acknowledge signs of illness. Thus, they explained that their first course of action when experiencing ill health is to overlook it or wait it out in the hope that it will go away. The men in the FGDs said that they would not show signs of illness to the community and would not discuss sickness with their friends (the exception to this was sexually transmitted infections (STIs) amongst young men). FGD respondents reported that men tend to wait until they are very ill before they will agree to go for treatment, and even then, they usually go only in response to the urging of other people.

Men in the FGDs reported that if an illness were to persist, they would first seek services from a traditional healer both because traditional medicine is located in the community and thus does not require the time off from men's duties that a health centre visit would require, but also because they were more comfortable with traditional medicine. This course of action is echoed in the literature where it has been noted that men demonstrate a preference for traditional healers. (This point is discussed in more detail below.)

Men also say they delay seeking treatment because of the responsibilities placed on them to provide financially for their families. Men in the FGDs spoke of the need to work and made it clear that they did not feel they could leave their income-generating activities to go to the health centre to seek treatment for themselves. There was a sense that they have to stay working in the field because they cannot afford not to do so; that is, that leaving work and going to a health centre would be seen as

shirking one's duty to earn a living. Men in the FGDs also spoke of their willingness to pay for the health services of their family members but mentioned that they were reluctant to use scarce family resources to protect their own health.

There are significant gender differences in how men and women view modern medicine. Whilst it is noted that women's first choice for health care is the modern health centre, men show a clear preference for using traditional healers. Men in the FGDs explained this preference in terms of traditional healers being closer and therefore requiring less time away from work. They also said that men get better results from traditional healers than do women. Msiska et al. (1997) attributes men's preference for using traditional healers to the fact that the healers have fewer requirements, such as requiring men to bring in their partners for STI treatment, than do public health centres.

It should also be noted that men are also more likely to self-treat and use pharmacies than are women. The 2001 DHS (Central Statistical Office et al., 2003) shows that men are twice as likely to go to friends or a pharmacy to treat an STI than are women. This may be because male gender roles allow them to be out and about in the community more, whilst restrictions on male-female interaction and women's domestic responsibilities keep them closer to home. It also may be that women are intimidated by dealing with pharmacists and do not want them knowing their health concerns.

In summary, at least according to the FGD participants, women are more aware of the need for health services and more willing to use modern health services than are men.

4.1.3 Negative perceptions about institutional deliveries

When considered against the high percentage (90% to 95%) of pregnant women who receive some sort of antenatal care, the low number of institutional births is a curious phenomenon in Zambia. Whilst there are likely to be several causes for the decline in numbers, one may be in the way social attitudes regarding the ways in which women's fertility is demonstrated and the value it has as a symbol of her womanhood and attractiveness to men.

Amongst some groups in Zambia, the ability of a woman to bear children is highly prized and seen as confirmation of her value as a woman and her attractiveness as a wife. Women's primary task is to be good at having children, that is, to deliver children easily. Women who have difficult or complicated deliveries are thought to be less good. A woman's fertility is only demonstrated by her ability to endure and overcome the challenges of childbirth on her own. Because childbirth is considered natural, something women "should" be able to do, many people feel that women should not need the assistance of modern health services to make it easier to deliver (Shankwaya, 2009).

These beliefs lead to the perception that women who choose to deliver in a health centre are conceding they need help, or cheating because the health centre offers comforts and medical assistance that spare them from the risks and challenges of a home delivery. The NHSP (2011-2015, 38) observed that one of the challenges to promoting institutional births is "a notion that seeking care early in the delivery process is a sign of weakness." As a result, to prove their fertility, there is considerable pressure on women to deliver at home.

When probed as to why women did not want to go to the health centres to deliver children, the women in the FGDs explained that they thought if they went to health centres, they would be forced to have "medical operations", or procedures (presumably Caesarean sections). Given that women's fertility is demonstrated through childbirth, there may be a perception, as there is in other countries, that a delivery by Caesarean section is not "real" childbirth in that it is not done the "natural" way, and that it is somehow cheating because it does not force women to endure the pain of a vaginal delivery.

4.1.4 Different interests in family planning

Amongst many social groups in Zambia, children are seen as a symbol of men's virility and thus men derive status from having many children. It is not surprising then that men desire a larger family more than they desire women. Observers of family planning uptake frequently point out that this dynamic discourages the demand for family planning methods. In cultures where there is a high premium on

having children and on women's fertility, observers note that women often forgo acting upon their personal desire to limit or space their children because of societal pressure and the preference of their husbands.

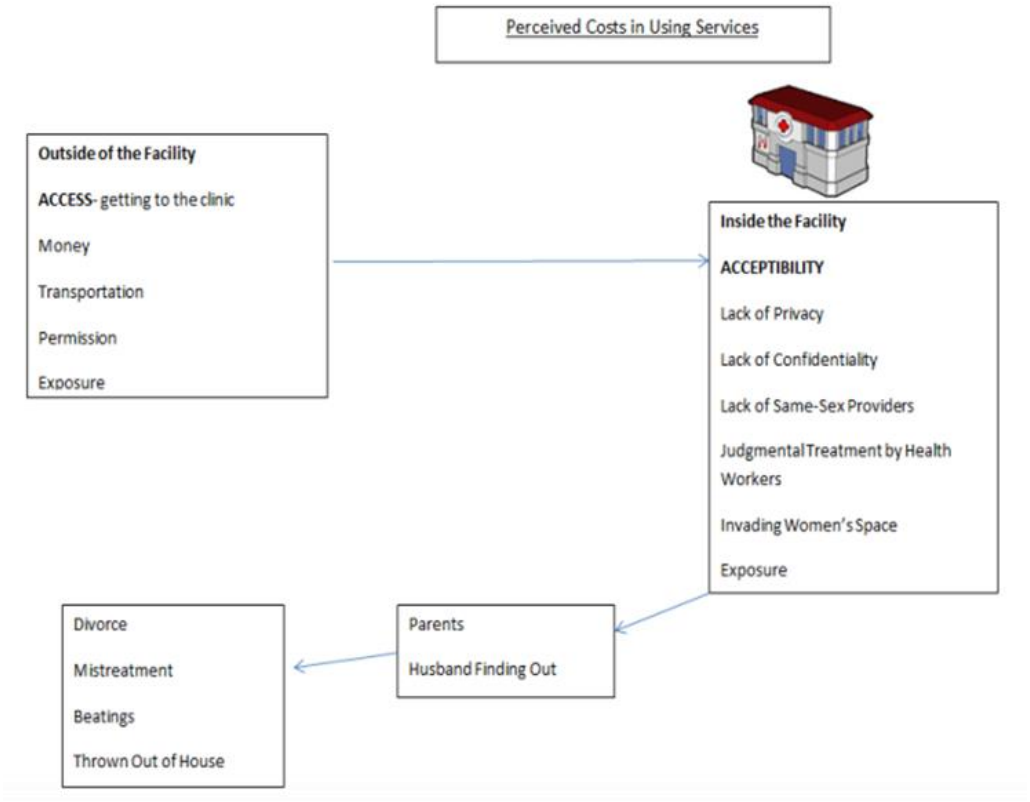
The term "unmet need" is used to describe situations in which women say they want to use family planning services but do not. The presumption is that women, on their own accord, would choose to use family planning methods, but that the aforementioned pressures – from society in general to men and husbands in particular – to have many children prevent women from acting on their desired need. This concept of unmet need is problematic because it does not acknowledge that women often make a conscious choice to please their husbands and fulfil their traditional gender roles by not using family planning methods, particularly long-term methods.

4.2 How gender creates obstacles and costs in using health services

The above discussion articulates how gender considerations affect the demand for health services. This section highlights ways in which gender creates obstacles to men and women's use of services. By identifying the obstacles, it seeks to prompt health planners to think about what kinds of health system changes could be made to eliminate or mitigate these obstacles and make health services more accessible and acceptable for both men and women.

As noted earlier, men and women encounter many kinds of obstacles when they try to access and use services. This analysis distinguishes between those that people anticipate they will incur in getting to the health facility (accessibility) and in using health services provided at the facility (acceptability). Another distinction is between challenges that occur as a result of dynamics that originate outside the facility (in the way gender is constructed or dynamics that occur in family, community and culture) and those that occur inside the facility or health system as a result of the way services are offered. Dynamics that occur inside the facility (such as the behaviour of health workers) usually are within the immediate mandate or purview of the health system to address. Obstacles outside the facility, in the community and culture (such as the attitude that some treatment-seeking behaviours are viewed as a sign of weakness in men), demand that the health system expand its traditional purview to include changing attitudes and behaviours at the societal and community level. These can be broken down into practical costs (such as time and money); psychological costs (such as humiliation or embarrassment) and social costs (which can be practical or social) that may result from other people knowing someone has used services. An example of the location of these costs is provided in Figure 4.

Figure 4: The Perceived Costs of Treatment Seeking



4.2.1 Accessing Services: Social obstacles outside the health centre

Women and health decision-making: Firstly, it should be noted that even though women are perceived as having more health information than their husbands, women are not likely to feel they have the power to make a decision over whether or not they, or a family member, should go to a health centre. The ability to make decisions regarding their own health and the health of their families is further compromised when they marry. The World Bank notes that women lack the "right" to make decisions about going to health centres (Milimo et al., 2004). Fifty-three per cent of women interviewed for the 2001 DHS said that someone else makes decisions over women's health care. By 2007, these attitudes appeared to have changed slightly in favour of women's decision-making. In 2007, 34% of married women felt that men "usually" made the decisions regarding women's health, whilst 33% of married women reported that decisions regarding women's health were made jointly and 31% felt that such decisions were "usually" made by women (DHS 2007). These data show that a sizable proportion of women are not likely to feel empowered to make decisions regarding their own health care without consulting a man. It is men who make the final determination on whether or not a health centre visit is made. As a result, a women's first course of action may be to bring a health concern to the attention of their husbands. So from the onset, the decision to go or not to go to a health facility is exposed to male input.

Women's Need for Permission: Even if women were to decide to go to a health centre or knew that they wanted to go, many feel they must still ask their husbands for permission to do so. Women in both FGDs spoke of the need to ask their husband's permission in order to seek health services and said they spent a significant amount of time trying to convince their husbands to let them go; this task is made more difficult by women's lack of education and bargaining power and by traditional gender norms that make it difficult for them to challenge male authority.

In such cases, women in the FGDs reported they felt they had to justify the need to go to a health centre to their husbands who, according to the female respondents, often were reluctant to allow them

to go. The women reported husbands and wives often disagree about when and under what conditions to go to a health centre. Women said that men tell their wives to wait out an illness or to seek traditional remedies because of the time and financial cost involved in going to the health centre. Interestingly, male respondents felt that when women suggest going to a health centre, men always agree. Men reported that men and women sit down together and discuss if a child is to go and only "1 out of a 100" times would a man would disagree with his wife on whether or not to take the child. They said that it was only if a man were drunk or deranged that he would not allow his wife to take a child to a health centre for treatment.

If women felt the circumstances were serious enough, they might go to other members of the community and ask them to try to influence their husband's decision, and in dire circumstances, women reported they would try to go to a health centre by themselves, without male support.

If women do not ask for permission, or disobey their husbands, women risk their husbands' disapproval or mistreatment, which is a legitimate concern given the 2007 DHS data that showed that 42.3% of men felt that a husband was justified in beating his wife if she went out without his permission (DHS 2007). If women violate the expected behaviour of a good wife by going to the health centre on their own, without first securing the permission of a male family member, or worse, they disobey their husband's refusal to let them go, they may risk social sanction from neighbours and family members. This occurs frequently in other areas of the world and has been given as a reason why women do not take their children to health centres even in dire circumstances (Rose Amolo).

The need for permission, or women's lack of decision-making power, exposes health decision-making to men's input. This is important in that, at least according to the participants, men are less knowledgeable about health issues and they are also less likely to be in favour of using public facilities. Because men are less likely to be informed about health issues, according to the participants, they have less medical information upon which to base a decision. Thus, the decision over whether or not to seek treatment is not usually made by the person with the most relevant information, but instead is based on traditional gender norms of male authority.

It is not just permission that women need in order to access health services. The fact that men control the property and resources, even in situations where women earn an income, makes it necessary for women to ask men for these resources. Women do not have the capacity to mobilise the money and transportation that they need to go to a health centre without male support (Shankwaya, 2009). Whilst women often have control over small household expenditures (DHS 2007), it is likely that a visit to a health centre would exceed these amounts.

Thus, women face significant hurdles even before they set out for the health centre. These hurdles jeopardise health outcomes.

Sexual and reproductive health services: In many cases, the obstacles that women encounter in seeking access to treatment increase dramatically when women seek health services related to her sexual and reproductive health (SRH). The gendered expectation that men control the terms of sex and women's sexuality and that women's sexuality is to serve men, coupled with women's social and economic dependence on marriage and pressure to please their husbands, subjects women's SRH decision making to male input and control.

The literature is rife with reasons why men often oppose their wives seeking SRH services such as family planning and STI (including HIV) testing and treatment. Women FGD respondents explained that within a couple, there is a perception that it is always the man who is presumed to be HIV positive. Therefore, a man may respond negatively to a wife's request to be tested because he does not want to know his status. Being HIV positive would reflect negatively on him and he would suffer the social stigma and the burden of knowing.

Another cause for a man's refusal to let his wife seek SRH preventive or testing services may be that men do not want their sexual pleasure compromised by methods of protection. For example, the DHS 2001 reported that 36% of men felt a woman had no right to ask a man to wear a condom.

Men also respond negatively to a wife's request for HIV testing because of the presumption that women simply have no right to protect themselves. Asserting the desire to be tested suggests that women have a "right" to protect themselves, or a right to do something that would jeopardise their husbands' sexual pleasure or challenge the terms of sex, which the husband is expected to dictate. Husbands may think it presumptuous that their wives should feel they have the right to protect themselves or to take precautions; it would indicate that their wives valued their own health status over the sexual pleasure of their husbands. As mentioned above, 36% of men felt a woman had no right to ask a man to wear a condom (DHS 2001).

The literature also provides evidence that women's fear of the male response results in women's self-limiting their use of SRH services[4]. For example, a 2007 Human Rights Watch report found that fear of domestic violence had a direct and harmful impact on the ability of women to initiate antiretroviral drug (ARV) treatment and to adhere to treatment. The report noted that women feared violence at the hands of their husbands or intimate partners when they mentioned HIV testing, sought testing, disclosed their status and received their antiretroviral drugs.

Montgomery's (2012) study of HIV treatment and prevention found that women felt they had to get the permission of their husbands to participate in the study. Participating women felt that if their husbands found them using gel without their knowledge, they would be beaten or otherwise mistreated.

Murry et al. (2009) has similar findings: Many respondents indicated that local women do not start or continue with ART [antiretroviral therapy] as the medications are difficult to hide. Respondents described fear of divorce or mistreatment by husbands once ART/HIV status was discovered. Respondents also suggested that women lack the possibility of economic independence, and many "would rather die than lose the marriage", and that therefore women really have no choice as to whether or not to take ART. These responses suggest competing motivating factors such as sustaining a marriage and economic livelihood (5).

Similar outcomes were reported in a study by Kaona (2008) in which women did not use ART because they feared violence from their husbands or divorce. Jones et al. (2008) also highlighted how male acceptability had a determinant impact on women's choice of contraception.

There are numerous examples of women's decisions to forgo seeking services because the women fear their husbands will either accuse them of having sexual partners outside the marriage, or that men will find out about their extramarital relationships and beat them or divorce them.

> Studies show that one of the major obstacles to women seeking SRH services is their fear that their husbands or partners will object. This suggests that women would be more likely to use these services if men supported their use, or if services were offered in a way that allowed women to use them without men's knowledge or input.

There is also cause to believe that whilst a woman might use SRH services without her husband's permission once, she might not continue to do so if she feels the risks are high that her husband will find out, or if she is not able to protect her health or sustain treatment over the long run. For example, she might get an STI treatment once – usually at considerable cost and inconvenience and risking her husband's disapproval or punishment – but if she cannot prevent being re-infected, then she may feel it is not worth the costs of returning for repeat treatment.

Here is it important to reiterate that the "costs" that women are likely to incur in seeking and using health services are not only money and time but also divorce and beatings.

[4] The reasons why men might object to women using family planning services were discussed in the previous section (4.1.4) and thus will not be discussed here.

Similar obstacles face adolescents seeking SRH services. Societal attitudes discourage premarital sexual relations and, whilst parents may look the other way to benefit from their daughter's relationships with older men (popularly referred to as "investors"), they are also likely to condemn their child if they learn that the child is sexually active. For their part, youth fear their parents' response upon learning this. Adolescent FGD respondents expressed fear of being beaten, forced to marry or thrown out of the house. Therefore, youth do not want their parents to know they are seeking SRH services. Also, like women who seek services without their husband's approval, youth who seek services without their parents' approval must pay for transportation to the health centres and the services with their own money.

The lack of confidentiality and exposure in their local health centre may force women and youth to go to a health centre in a different town where they will not be identified. Of course, this creates additional costs and often results in their delaying treatment.

Practical obstacles outside the health system: Time/distance/money: In the FGDs, distance was the most frequently mentioned obstacle that people face in accessing services. But it is a different obstacle for women and men. Women's "time poverty" and confinement to the domestic sphere may make travelling long distances alone too intimidating for them to undertake. Whilst male heads of households might have a male family member accompany the woman, this doubles the travel costs and increases the overall cost burden of seeking services.

When asked to rate specific challenges to seeking treatment for the 2001 DHS, 66% of women said that their major obstacle was securing money for transportation to the health centre; 45% said that distance was a major obstacle. FGD participants tended to group distance, time and money together. Other authors have also noted that these three obstacles were identified as significant barriers to treatment, particularly amongst women (see Claeson et al., 2001). Interestingly, the actual fees charged for health services were not listed by participants as an obstacle to using services. Instead, participants tended to refer to the costs of transportation to the health centre or the opportunity costs incurred by having to leave work to go to the health centre. This again, has been noted in the literature particularly amongst women (see Needham, 2001).

The 2006 Milimo et al. study for the World Bank showed that women spend roughly 5-6 more hours a day working than men, yet there is a perception amongst both men and women that men cannot afford the time to take family members to health centres or to use health services themselves. This may be because a women's role is to take care of her children, so taking a sick child to a health centre is seen as part of her child-rearing duties. In contrast, a man's role is to work in the fields, so accompanying a sick child or his wife to a health centre represents a significant departure from his gender role. These perceptions may explain why men are likely to feel they incur more opportunity costs in going to a health centre than do women, even though women spend more time working and thus have greater real opportunity costs than men.

4.2.2 Acceptability: Practical obstacles inside the health centre

Waiting Times: Long waiting times at the health centres are often cited in the literature as a significant deterrent to the uptake of health services (Msiska et al., 1997), but current FGD respondents did not voice this issue so strongly. What did come out in the FGDs was the fact that men are given preferential treatment by health care professionals and often allowed to jump the queue of patients waiting to be seen. According to the FGD participants, allowing men (and parties with men) to jump to the front of the line is so established a practice that families often take a man with them specifically in order to be seen faster. In one FGD with women, a woman complained that she did not like the behaviour of health workers because they did not make decisions about who should be seen based on medical criteria; they simply told women to go to the end of the line. Yet, the same woman, and the rest of the women in the FGD, later said that a man being allowed to go to the front of the line was perfectly acceptable.

The preferential treatment shown to men within the health centre is the result of social norms that also privilege men outside the health centre. Allowing men to jump the line may be the result of the perception that men's time is more valuable than women's, as mentioned earlier. It may also be the

result of other dynamics. For example, health workers may feel pressured to move men to the head of the line, fearing that men would get impatient and make trouble if they were not seen before women. Female health workers may feel uncomfortable engaging with male patients, so they may want to rush them through the health centre. It also may be the case that the lack of privacy, and the preponderance of women in the health centre, might encourage health workers to move men through the health centre as fast as possible to minimise the discomfort or embarrassment their presence might cause to the remaining women. Whatever the reason, the result is the same; men are less likely to experience long waiting lines. Whilst both women and men may see this as a natural reflection of social norms within the health facility, it can have some very negative health consequences.

Hours of Operation: FGD participants did not mention hours of operation as an obstacle to service uptake. However, Shankwaya (2009), Campell and Graham (2006) and Stekelenburg (2004) note that limited operating hours may be one reason for the low levels of institutional births. Shankwaya notes that in some places, health centres are only open from 7:30 to 1:30 in the morning and from 14:00 to 16:00 in the afternoon, making it impossible for women and families to plan on delivering their babies at the health centres; instead, they simply plan on having them at home.

4.2.3 Acceptability: Psychological/social obstacles inside the health centre

Requirements to bring partners for treatment: Another obstacle that could result in both practical/psychological costs is the requirement that patients receiving treatment for STIs bring in their partners to be treated. This was not mentioned in the FGDs as an obstacle to service uptake, but it has been noted in the literature as a reason why men and women prefer to seek STI treatment from traditional healers instead of at public health facilities (Msiska et al., 1997). Ndulo et al. (2000) found that men who had more than one partner did not want to use public health services because they did not want to experience the social discord that would result from having to take several partners in for treatment at the same time. According to Msiska et al. (1997), women face a somewhat different problem: they are reluctant to tell their partners they are experiencing symptoms of an STI, and were not likely to have the power to make their male partners accompany them for treatment.

Women's Domain: Comments made in the FGDs suggested that there was an assumed division between men and women's health services. The conversations reflected the presumption that women used services at the public health facilities and men sought services from traditional healers. Participants attributed this difference to the fact that women were recipients of more public health information and that traditional medicine did not work as well on women as it did on men. This assumed association of women with modern health centres and men with traditional healers exacerbates the perception amongst men that public health centres are a woman's domain.

This perception is often reinforced by behaviour change communication (BCC) campaigns and health information geared specifically to women, and by the fact that most of the intake health care professionals are likely to be female. The perception may also be reinforced at the facility by the predominance of women amongst the clientele. Waiting in areas where the sexes are mixed, but where women outnumber men, may embarrass a man. He may feel as though he is violating a social norm by invading women's space. Social norms of male/ female interaction are also likely to be violated by the lack of privacy in the health centre so that men feel embarrassed to be exposed to women's personal business and vice versa. Men also may be embarrassed by being seen by other men in a space that is associated with women.

All these factors are deterrents to the uptake of health services in other parts of the world and have prompted the emergence of male-friendly health centres. Whilst FGD participants did not mention this idea specifically, when asked if they would be more likely to use health centres if there were "men-only times" or separate entrances and waiting rooms for men, the male participants responded emphatically that they would.

Physical Privacy: The literature shows that lack of privacy is a key inhibitor to the uptake of health services (Cleason et al., 2001, Mrish et al., 2007). On the one hand, the lack of privacy means that clients are seen by other people either going to the health centre or in the health centre itself. This risk of exposure is often exacerbated by the way in which the health centre is set up and operates. For

example, where the location of the health centre is not clearly indicated, people must ask for directions; also, security guards may ask people where they are going (Msiska et al., 1997).

Lack of privacy has particular consequences for youth and married women. In the FGDs, youth spoke about the fear of their parents finding out about their seeking care for an STI. They spoke of their fears of being kicked out of their homes, disowned, or forced to marry. It should be noted that they have no problems going to health centres for other medical concerns.

This fear of exposure is compounded when sexually related services are offered in a way that is obvious – for example, a voluntary counselling and testing (VCT) centre or an STI centre. This came out specifically in the FGDs with adolescent males who spoke of their embarrassment of being seen going to a STI health centre. Young men said that they are reluctant to go to such a health centre; they would be much more likely to go if the STI services were integrated with other services, or offered in a way that people would not know what service they were seeking.

Similarly, anecdotal evidence suggests that the fear of exposure causes youth to travel to different towns where they feel they can receive treatment without their parents finding out about it. This adds a number of practical and logistical obstacles to an already challenging process.

The lack of privacy or exposure has a similar effect on women. The literature offers many cases in which women cite lack of privacy as a major impediment to their desire to seek services – however, it is unclear if this is because they fear their husbands finding out, or because lack of privacy would violate social norms regarding modesty.

Operational procedures that assume men will accompany women into the intake or examination room or allow men to make the health decisions regarding women (and other family members) can also violate a woman's right to privacy and may discourage women from going to public health facilities, especially for SRH concerns. Women may choose not to go to a health centre if they feel that their husbands will be allowed in the intake room, or if they feel they will be pressured to reveal personal information that they would otherwise keep from their husbands. If they do go to the health centre, they may omit important parts of their medical history that they do not want their husbands to hear.

The exposure to which people are subject within the health centre also compromises people's sense of modesty and violates social norms about men and women seeing each other without clothes or in personal situations. Being seen or seeing others in personal and compromised positions may be a source of humiliation and embarrassment, especially in small villages where a client is likely to know other clients or the facility health workers. This lack of privacy may contribute to the low number of institutional births. Women and families may not want to deliver in a health facilities because of the fact that during childbirth, women are very physically exposed. Lack of privacy also allows other people to see or hear a women's cries of pain and interpret it as a sign of weakness, thus compromising her status and sense of womanhood.

Lack of Confidentiality: In contrast to the lack of privacy, which is caused by the physical setup of services, the lack of confidentiality refers to health worker's sharing information about patients with people, particularly husbands or parents. The fear of lack of confidentiality has been cited as a deterrent to service uptake, and was a particular concern of young men in the FGDs.

In the FGDs, participants could cite at least one instance of a health worker violating a patient's confidentiality. Whilst the lack of confidentiality is less of a fear than is being seen by other people in the health centre, being able to cite an example of when a patient's right to confidentiality was compromised appeared to be enough of a disincentive for adolescents to avoid using public health facilities. In FGDs with adolescents, both young men and young women demonstrated considerable distrust of health workers and said that they would be more likely to trust people their own age with personal information.

Negative Attitudes of Health Care Providers: There are a number of ways in which the behaviour of the health workers creates obstacles and social costs for patients in using public health services.

The rude and judgmental treatment that clients receive from health workers was the second most frequently mentioned deterrent to using public health services mentioned in the FGDs (the first was distance).

This is reflected in the literature (Msiska et al., 1997) and was voiced far more often amongst women in the FGD than amongst men, which is likely to be a reflection of the preferential treatment health workers give men (Claeson et al., 2001).

As noted earlier, the FGD affirmed the fact that the overall privileged status of men in society is reinforced in the health centre setting through the behaviour of the health workers. Both male and female participants noted that if a man were the patient, then the case would be seen as more serious and thus would warrant the immediate attention of health workers. Participants also said that men were presumed to be less patient than women, and therefore health workers would see to men's needs first. Traditional gender norms also may make female health workers less comfortable asking men to wait in the long lines or to resist giving men what could be interpreted as preferential treatment.

Health workers often hold the attitudes about gender that exist in the society as a whole and they may bring their personal attitudes into their interactions with clients. In FGDs done for a study in Zambia, Msiska et al. (1997), the derogatory remarks made by health workers regarding patients' loose morals were cited as a primary reason for clients' avoidance of public health centres. A study on treatment-seeking behaviour for STIs noted that health centre staff applied different labelling to men and women clients experiencing STIs. Women were referred to as *fimbusu* (toilets) or *hule* (prostitutes), whilst men were labelled as *kubusinsa* (having experienced an accident). The study also found that because traditional gender norms view women's sexual activity negatively, women incurred higher costs for STI services than did men. The authors also observed that these double standards and notions of appropriate norms for men and women's sexual behaviour affected the recognition of symptoms, the process of consultation and care-seeking behaviour (Msiska et al., 1997).

In another study done in Zambia, Ndulo et al. (2000) reported that the judgmental attitudes of health workers were a significant deterrent in people seeking STI treatment in public health facilities. This study noted that young people avoided going to health centres, fearing a scolding by health care workers. The negative conduct of health workers pushes people into seeking treatment from traditional healers who do not scold or make degrading comments.

Youth in the FGDs also expressed a fear of being shamed or embarrassed by health workers. Youth confessed that they are too shy and embarrassed to ask health workers for sexually related services, an indication of how unapproachable they feel the health centre staff are. Young people also mentioned that health workers are "too busy" to respond to their needs with the sensitivity and respect that they feel such discussions warrant.

Young women in the FGDs reported that whilst health practitioners are not likely to treat either adolescent boys or girls seeking condoms or SRH services well, they feel that the treatment they receive as young women "is worse". This confirms the findings of Msiska et al. (1997) that women tend to incur more social costs in seeking STI treatment than men because of health workers' conservative attitudes regarding women having sex. Ndulo et al. (2000) quoted one participant as remarking, "At the clinic, nurses scold young girls when they report to the clinic with an STD [sexually transmitted disease], so they are afraid to go there."

Adolescents also commented that they would feel more comfortable talking about SRH with someone their own age, confirming the notion that peer education is a best practice approach to engaging adolescents. Young men in the FGDs reported that they would be more likely to tell their friends and work through their networks to access family planning and HIV/STI resources.

Again, there are examples of ways in which health workers reinforce traditional gender norms and, as a result, inadvertently discourage the uptake of services or fail to implement existing approaches specified in the NHSP. The MOH has adopted a "positive male involvement" approach to engage men in family health. This approach will be discussed in more detail in Section 5.2.4. However, it is important to note that this approach requires optimising opportunities to provide men with health information and to engage them in matters relating to family health. Allowing men to jump the line

and moving them through the health facility quickly actually undermines the primary objective of the "positive male involvement" approach.

For their part, health workers may be less comfortable talking to men, particularly about men's sexual health, or keeping men in the facility to offer them additional, and much needed, health information. Such attitudes can short-change men's health. Whilst there are efforts to integrate health services for women, especially around HIV and antenatal care, there has been little effort to optimise men's presence in the health centre to provide men with additional health information and services. Again, this dynamic has obvious repercussions for the quality of care patients receive.

One male ZISSP staff member recalled taking his child to a health centre. The health worker made disparaging comments about the absent mother, implying that the mother was not performing her motherly duties. Again, such health worker behaviour does not promote positive male involvement in family health.

Lack of Same-Sex Health Workers: The lack of same-sex health care providers has been noted as a significant deterrent to health services uptake in many parts of the world where gender norms and social dynamics similar to those in Zambia exist. Where such cultural norms dominate, men appear more willing to "let" their women be seen by female doctors and there tends to be less social sanction towards women going to health centres on their own without first getting permission from a man. Where there is a strict division between the sex of providers and women can be assured they are getting a female doctor, women tend to have more decision-making power over both their own health and the health of their children. The availability of same-sex providers has also been demonstrated to have a positive impact on patient/provider interaction, appropriate diagnosis and adherence to treatment.

The impact of the lack of same-sex providers on health service uptake in Zambia has not been widely explored. The study by Msiska et al. (1997) on the uptake of STI services observed that the social costs of using public services is higher for women given that most of the health workers are male. There is also anecdotal evidence to suggest this. In a health centre located in one of ZISSP's priority areas, ZISSP staff observed unusually high numbers of institutional births. As mentioned earlier, Zambia has high levels of antenatal care, but low levels of in-facility births – and high levels of maternal mortality. Then, at a specific point in time (2012), ZISSP staff, during one of the EmONC post-training follow-up visits, observed a significant drop in the number of institutional births in some centres. When ZISSP staff investigated, they were told that the earlier high numbers of health centre deliveries were due to the fact that a female nurse was on staff. When the female nurse left, the number of health centre deliveries started to decline.

There are so few female doctors and male nurses in Zambia that it is unlikely that people have considered what it would be like if there were same-sex providers. However, men in the FGDs did mention that they would be more willing to use health services if there were more male health care workers and "men-only" hours.

4.3 How gender affects the perceived benefits of using health services

The above sections outlined some of the ways in which gender affects the demand for health services as well as some of the ways people experience different gender-related obstacles or costs in using services. This section outlines some of the ways in which gender affects the benefits people perceive they will gain from using public health services.

What benefits people expect to receive by using public health services is shaped by a variety of factors including their expectations of modern medicine, their access to health information and their experience in using other types of health services.

However, on a fundamental level, the benefits that people expect will depend in large part on the ability of the health system to deliver improved health outcomes. Therefore, this section discusses the ways in which gender norms and dynamics that occur in and outside the health facility can impact

health outcomes, and it argues that addressing them will be essential to improve health outcomes and demonstrate positive results from using public health services.

4.3.1 How gender affects expectations of health services

Interestingly, Shankwaya (2009) notes that women's satisfaction with public health services depends more on how they were treated by health care workers than the quality of care they received or whether or not the visit resulted in improved health outcomes. This suggests that improving the capacity of health workers to positively interact with clients would have a significant impact on improving women's overall satisfaction with using health services.

Similarly, how people view the benefits of public health services are likely to be considered against other options for treatment that are available to them. The DHS and other sources suggest that men have greater access to a broader range of health services than do women. For example, men tend to use pharmacies more than women do (DHS 2007). This may be the result of restrictions on women's time and movement that make it difficult for them to go to the pharmacy in the town or village. Similarly, it has been noted that men are more likely to self-treat illness than women, again likely a reflection of their greater access to pharmacies and a wider social network from which to get health related information and resources.

However, men in the FGDs voiced a clear preference to use traditional healers over public health facilities. This may be because the traditional healers are located nearby, in the villages, and so did not require the travel time and money involved in going to a health centre. Others say they prefer traditional healers because they are less judgmental than public health workers and do not have other requirements for STI treatment such as bringing in partners (Msiska et al. 1997).

4.3.2 How gender can affect health outcomes

Several of the gender norms and behaviours – many of them so embedded in our cultures that their consequences go unnoticed – that have been discussed both in the literature and in the FGDs can have enormous impact on health outcomes. It is presumed that addressing these practices will improve the benefits people feel they will gain by using health services.

Traditional gender norms that discourage men's treatment-seeking behaviour (due to embarrassment or stubbornness) clearly result in delays in timely health care. By the time men arrive at the health centre, their symptoms are likely to have progressed to such an extent that the treatment options are more limited and the potential for positive health outcomes is seriously jeopardised. When men do not get immediate positive health benefits, they often blame the health centre, the doctor or modern medicine, rather than the delay in seeking treatment. The failure of the health system to address this concern will likely continue the cycle of male dissatisfaction with health services.

Women's lack of being able to decide on their own when to go to a health centre – and their lack of resources to pay for transport and health care services – also results in delays in seeking treatment. FGD participants reported that women wait for permission from their husband or his designee to go to a health centre on their own. This takes times and delays seeking care. Additionally, the husband's decision about granting permission is based on traditional gender norms, not rational medical criteria – meaning that the decision-maker is often the person with the least amount of health information. Women also waste time trying to convince their husbands of their need for care.

Operational procedures and protocols that give male family members decision-making power within the facility also can delay treatment and produce negative health outcomes, which, again, is blamed on the doctors or modern medicine rather than the delay in initiating treatment. These protocols also increase the costs of care.

The negative impact of the lack of female decision-making has been acknowledged and has been the impetus for the creation of safe motherhood groups and community safe motherhood committees around the world. However, its impact on child health and malaria (MOH priority areas where getting immediate treatment can be important) have yet to be explored thoroughly. Nor is there obvious

evidence that serious efforts have been made to bring this issue into the framework of quality improvement and health centre care programmes.

Health centres allowing men and parties with men to receive treatment before those without men – without regard to medical factors – can also jeopardise patients' quality of care and health outcomes.

Yet another cause for delay in treatment is the lack of privacy and fear of exposure, which may lead youth and women to forgo treatment or decide to travel to facilities where they think they will be less likely to be seen or talked about.

4.3.3 Provider-Client Interaction: Diagnosis and adherence to treatment

Operational procedures and practices that presume that men will accompany their wives to health facilities, allow doctors and health professionals to discuss women's health information with men and expose women's decision making (regarding their own heath) to male input may have a number of negative health outcomes. Firstly, it may limit the kind of information women relay to health workers, affecting the ability of the health worker to make a proper diagnosis. Secondly, when men make decisions regarding women's health, they may have less health information than do women; they may make decisions that women do not agree with, or they may make decisions that are based what men think women want, rather than what women want. Thirdly, such protocols also allow men to make decisions regarding women's health that advance the interests of the man rather than of the female patient.

Gender dynamics also affect provider-client interaction and therefore the health outcomes. The fact that most doctors are male and most intake workers are female can have negative health outcomes. The recent appeals for more gender-sensitive health services come largely in response to the failure of health care professionals to understand the social reality, and to take gender norms into consideration, when interacting with female or male clients. When women engage with health workers they may be intimidated and reluctant to ask questions. As a result, they leave the facility without knowing how to adhere to treatment or to follow up.

Similarly, it is claimed that health workers do not understand that women have different restrictions, skills and capacities, which may present challenges to health workers who are not trained to be gender-sensitive. Because of this, health workers do not take the time to engage with women and ask the right questions. This can result in an inaccurate diagnosis or prescription of treatments, which women can realistically follow. Unchallenged gender norms and a lack of gender sensitivity can also short-change men's health. For example, female health workers may not give men instructions for fear of being seen as bossing men around. In this way, men may not get the health information they need or want.

Moving men in and out of health centres quickly, with the assumption that their time is more valuable than that of women, also deprives men of the opportunity to ask questions about other health concerns and for health workers to give men other types of health information. It does not create an environment in which men feel they are welcome or have a right to be in the health centre. That is, it reinforces the notion that men are trespassing on women's space, or worse, that it is shameful for men to be sick and in need of health services.

This section demonstrated how gender affects the demand for health services and how it can create different obstacles and challenges for men and women when the desire to use services has been established. It has also identified ways in which the construction of gender and gender norms can compromise health outcomes, which in turn can inhibit the use of health services in the long run. Rather than treating these obstacles and costs as natural by-products of culture, these dynamics should be considered serious impediments to health service uptake, and as such should be addressed from a health systems perspective. Best practices approaches to doing this will be provided in Section 5.0.

5. Gender-Based Constraints, Reported Consequences and Suggested Responses

Section 4.0 outlined the ways in which gender can affect the uptake of health services. It demonstrated how gender can diminish the demand for certain high-impact health services and highlighted the challenges and obstacles that men and women expect to encounter at different points along their treatment-seeking trajectory. Section 4.0 also discussed how gender norms and expectations could negatively impact health outcomes and therefore the benefits that people anticipate from using health services.

It is presumed that the uptake of health services depends on the client's perception that the need to seek health services and the benefits of doing so will outweigh the obstacles and costs involved. Therefore, efforts to improve health service uptake will require increasing the demand for and benefits of using services and eliminating, or at least minimising, the obstacles that clients expect to encounter. In short, the health system must make the benefits of using health services outweigh the costs.

This section discusses some of the best practice approaches that can be used to address the gender-based constraints to health care seeking. It also discusses how health services can eliminate instances where gender norms negatively impact health outcomes and thereby improve the benefits people think can result from using health services.

> The intention here is not to prescribe precise activities for the MOH, PMOs and DCMOs to undertake. Instead, it is to explain the rationale and to provide examples of approaches that other countries have used successfully to address gender-based constraints to the uptake of health services. This will enable Zambian health planners to make more informed decisions about what would be beneficial to adapt for use in the Zambian context.

5.1 Accommodative and transformative approaches to address gender norms

Addressing gender-based constraints calls for action on two levels: on one level, efforts must be made to radically transform the cultural norms and attitudes that give rise to these constraints in the first place. On another level, the health system must be made more sensitive and responsive to gendered reality so that men and women are more able to use, and more comfortable using, services.

These two levels correlate to different characteristics that the United States Agency for International Development (USAID) uses to label programme approaches relating to gender. According to USAID's model of gender approaches, programmes that acknowledge and work within existing gender norms are considered to be "accommodative".

Accommodative programme approaches attempt to make services more sensitive to the gendered realities in which people live. They usually relate to the way health services are offered, and they include efforts to make it easier for men and women to get to health centres or to make health centres more gender-sensitive.

However, whilst these programmes may try to make services easier for men and women to use, they do not necessarily address the underlying gender norms that constrain use in the first place. For

example, whilst accommodative programmes may work to make it easier for women to use family planning methods without their husband's knowledge, these programmes do nothing to challenge the notion that men should determine the number of children a couple should have. Therefore, the immediate impact on these programmes may yield superficial results (in that women are able to use family planning methods), but the fundamental problem remains unaddressed (men make the decisions over the terms of sex and desired family size).

In contrast, programmes that challenge the underlying gender norms that impede demand for services or that create obstacles to using services can be characterised as "transformative". Such programmes are usually focused on helping individuals, communities and cultures critically reflect upon and challenge the underlying gender norms that often result in negative health outcomes; that is, they try to change the heart and minds of the community. For example, a transformative programme would work with men and women to challenge the perception that men are entitled to make all the decisions regarding the number of children a couple will have, or that women have no say in their own health decisions. Transformative programmes usually include BCC campaigns and community-led discussion groups.

The failure of accommodative programmes to yield positive results over the past 30 years signals the need for transformative approaches to promote positive and lasting social change. Today the international health community recognises that whilst there are many situations in which accommodative approaches might be necessary in the short term, these approaches should be accompanied by more transformative programmes in order to create lasting results.

Improving service uptake calls for efforts that function on both levels: Transformative activities are needed to challenge the gender-based constraints that inhibit the demand for health services or that prevent women from acting on the demand that they already have but cannot actualise (as discussed in Section 4.0). They would include addressing the gender-based constraints that inhibit male health-seeking behaviour, addressing the cultural need for women to prove their fertility through at-home deliveries and addressing the cultural assumptions that give men decision-making power (particularly over women's health) as well as those gender dynamics that make it difficult for women to challenge male authority.

Improving service uptake also calls for changes to be made in the way health services are offered, to minimise the challenges and costs men and women incur in using health services. These efforts are likely to be accommodative in that they are not necessarily designed to change the attitudes that create these challenges and costs and obstacles; they simply minimise exposure to them. For example, the health service should take active steps to eliminate the ways in gender-based norms compromise health outcomes and the benefits that people perceive they will gain from using health services.

5.2 Improving the demand for health services

Improving the demand for health services requires challenging the gender-based constraints that inhibit demand. In Section 4.0 these constraints were identified as those that interpreted male health-seeking behaviour as a sign of weakness, as well as those of women's "unmet need" and "inhibited demand", whereby women have the desire to use health services but choose not to because they anticipate a negative response from their husbands either to the outcome of the service (in the case of family planning) or to using the service or commodity (such as ART, institutional deliveries or condoms). Therefore, the first step in increasing the uptake of health services will be to address these gender-based constraints that inhibit the demand by challenging existing gender norms.

5.2.1 Challenge gender norms that inhibit men's treatment seeking

There are many well-documented best practice approaches that help both men and women examine and challenge attitudes that perpetuate the notion of men's health-seeking behaviour as unmanly or indulgent. These approaches often entail leading men and women through a series of interactive exercises, which encourage them to critically reflect upon and challenge existing perceptions about male health-seeking behaviour. The exercises help them to see how traditional gender norms about

"what it is to be a man" can result in negative health outcomes for men, to de-link male treatment-seeking behaviour as a sign of weakness, and to shift attitudes so that men feel more comfortable acknowledging ill health and seeking treatment. Such programmes encourage men and women to allow men to value their health and therefore to protect and promote it. Some of the better-known and evaluated projects of this type include Instituto Prumondo's Progam H and the USAID-funded Extending Service Delivery project's (2005 – 2010) *Healthy Images of Manhood (HIM)* activity.

Whilst initially these programmes focused on working with men, they soon recognised that men were not likely to feel comfortable seeking health treatment if the women around them maintained traditional gender norms regarding male behaviour, so they expanded the programmes to include work with women and communities.

Other effective community-level interventions include airing radio programmes, on which men and women discuss the negative impact that these attitudes have on men's health, and addressing negative behaviours in text books and advertisements and through church and youth groups. Cultural institutions, opinion leaders and religious figures are encouraged to take an active role in creating an environment in which men, and in particular young men, feel comfortable seeking treatment. Still other initiatives are positive deviance approaches, such as men speaking out and encouraging other men to acknowledge symptoms and seek treatment, and BCC campaigns that show it is not unmanly to seek treatment.

Make health centres more male-friendly: Whilst the traditional gender norms operate at the societal level, they are reinforced at the facility level by the behaviour of the health workers and the setup of the health centres. It is therefore important that the health facility change the way it offers it services in a way that is transformative – that conveys respect for men's treatment-seeking behaviour and promotes a positive image of that behaviour.

For example, health workers should not dismiss men's concerns or suggest that treatment seeking was unnecessary. Instead, they should be instructed to encourage men to value and protect their health and to optimise opportunities to educate men about their health when men come to health centres. Protocols could also be examined to see how they could maximise opportunities to educate men about their health needs.

Efforts towards this end include training health workers to challenge their own attitudes towards men's health. They should be trained to be sensitive to the fact that men may find it difficult to admit to illness or come forward with their health concerns, and to encourage men to acknowledge their concerns and to treat them with respect instead of minimising or dismissing the concerns. Training also is needed to make health workers more comfortable treating men and making men feel at ease within the health centre.

Health facilities themselves should be made more male-friendly. Efforts might include establishing "men-only" hours, separate waiting rooms for men and male-oriented literature and health information. They may also include offering services at venues that men attend, such as sporting events, and having male health workers. The intention is to reorient facilities in a way that does not presume that women are the only users and that signals that men have a right to use the health centres and that men should respect their health.

5.2.2 Challenge gender norms that encourage home deliveries

The NHSP recognised the need to challenge traditional attitudes that encourage women to "prove" their fertility prowess by having home deliveries. Again, this requires making fundamental changes in people's attitudes at the individual and community level. Such efforts include working with women, men and mothers-in-law to help them critically reflect upon and challenge the notion that exposure to the risks of at-home deliveries is the only "real" means. BCC campaigns and messaging should be used to educate communities about the negative outcomes that can result from at-home births. The messaging should portray the positive and responsible mother as one who takes the necessary precautions to bear a healthy child, not one who assumes unnecessary risks.

5.2.3 Challenge gender norms that prevent women from acting on their demand

Challenging gender norms that prevent women from acting on their demand requires questioning men's authority over women's health and the terms of sex, as well as the idea that women should compromise their own health goals to maintain the relationship. Activities towards these ends can be characterised under the following headings:

Programmes that build the capacity of women to assert their decision-making: Efforts to improve women's decision-making power usually entail building women's confidence and interactive bargaining and negotiation skills. Efforts may start with helping women feel they have the "right" to make decisions on their own and the autonomy to do so[5]. Efforts may also include increasing women's income-generating power through microfinancing initiatives or skills building so that women feel less economically dependent on men and presumably therefore more confident in asserting their interests. Other efforts include discouraging early marriage See the International Centre for Research on Women's Activities. http://www.icrw.org/what-we-do/adolescents/child-marriage[6] and "sugar daddy" relationships where the age difference exaggerates the power inequalities (such as the *Young, Active and Healthy Adolescent* (YEAH) programme in Ghana, as well as Tolstan).

Programmes that challenge traditional gender norms regarding decision making: Even when women feel comfortable asserting their own decisions to their husbands, they may be challenged by their husbands' family, religious leaders or neighbours. Similarly, women may not want to risk going to a health centre without their husband's permission not because they fear their husbands' response, but because they fear that other family members or neighbours will chastise them and call them a bad wife.

Over 20 years of programming focused on women revealed the need not just to change the attitudes held by women, but also those of society – especially "influencers" such as religious, traditional and community leaders, and mothers-in-law. It is interesting to note that there is more of an established relationship between the acceptance of women's decision-making and men's education, than there is with women's education (DHS 2007). This shows that, in efforts to promote women's decision-making, it may be more important to focus interventions on men than on women.

This awareness has prompted a recent wave of activities designed to create an enabling environment in which women can make decisions. Such activities aim to help women, men and entire communities reflect upon and understand the value and need for women to be able to act on their own, and challenge traditional behaviours by creating an enabling environment for women to make their own health decisions[7].

Other activities are interventions and exercises that help communities realise that health decisions should be made by people with the most information regarding the illness, rather than automatically by the man because of tradition[8]. These activities cite the dire medical consequences that can occur if women are unable to make critical health decisions. For example, safe motherhood groups often walk community members through what could happen if a woman were unable to decide when she should go to a health centre for delivery[9]. The negative outcomes of the lack of women's decision-making are also apparent in areas such as child nutrition and newborn health. Similar community-based efforts to recognise and appreciate the value of women and their contributions to the community, such as those developed by Raising Voices in Uganda, also have been proven to be effective in supporting women's decision making.

[5] See Better Life Options. http://prerana.org/programmes/better-life-options/and the work of Tolstan (http://www.tostan.org/) for example.
[6] See the International Centre for Research on Women's Activities. http://www.icrw.org/what-we-do/adolescents/child-marriage
[7] See for example: MenEngage, Program H (Brazil), IMAGE (South Africa) and Biruh Tesfa (Ethiopia), Raising Voices (Uganda), CHOICES (NEPAL) and Entre Nos (Brazil)
[8] See the LEAD and TSHIP Projects in Northern Nigeria
[9] See CEDPA's Safe Motherhood Project in Nepal

Promote couples' communication: An analysis of the 2007 Zambian DHS data shows that male support for women's decision-making may actually be greater than women believe it is, particularly around condom use and desired family size. For example, women feel that men have more influence over the number of children to have (DHS, 2007). These data suggest that these perceptions are less a question of male decision-making than the failure of men and women to come together to make a decision. It may be the case that both parties feel the other one has the decision-making power, or that neither party feels empowered to take proactive measures to bring up the topic. Therefore, providing opportunities and impetus for couples to discuss family planning and promoting couples' communication may greatly help women see the decision-making power they already may have.

Promote women's decision-making inside the health centre: Like the activities mentioned above that discuss the transformative power of health workers and health centres to enable changed attitudes amongst clients, changes in health worker attitudes and behaviours and facility protocols go a long way to change gender norms regarding male authority over women's health decision making. Ensuring that health care workers act in a way that respects women's decision-making, and does not defer to men, is likely to have an immediate effect on women's health decision-making. That is, if health workers do not ask men's permission or preference, men may be less likely to feel entitled to give it. Asking men for their opinion and allowing space for their input into women's health decision-making only reinforces the notion that it is a man's prerogative. Therefore, clinical care procedures should refute opportunities for a man to give unnecessary input in matters that could be decided by the woman's medical history and discussion with her alone.

There have been interesting efforts to train health workers to challenge their own perceptions about gender and to prevent them from allowing their personal beliefs to affect their professional behaviour. Similar programmes have designed tools and checklists to help health care providers see how they can promote women's decision-making and women's rights more generally within the health centre[10].

Other best practice approaches to promoting women's health decision-making include activities that encourage couples to feel that they have the power and responsibility to make decisions regarding family planning on their own without family or societal interference. These initiatives understand that discussions about decision-making are often difficult in that they require couples to suspend their traditional roles. They encourage couples to talk about the desired number of children, HIV protection and other sensitive issues so that the couples feel that they themselves can make decisions, not to have cultural norms dictate the decisions. This requires health worker training to counsel couples in a way that enables respectful communication and does not allow one partner to dominate the decision-making process[11].

Other efforts have pushed for changes within the health system that minimise husbands' undue influence in their wives' decisions. These include treatment protocols and quality improvement and clinical care processes that do not presume that a man will accompany his wife during intake procedures or in all discussions with physicians. Staff should be trained to be comfortable asking women directly about their health decisions, rather than communicating through the man.

Health centres can make other, more accommodative adjustments to promote women's decision-making. These may not actively challenge the traditional concept of male authority, but within the gender dynamics in which women live, they carve out some space for women to assert their own health-seeking goals. For example, they ease women's access to services or commodities (such as contraceptive injectables) that allow women to use family planning undetected. They also include integrated services so that women can receive the services they want without having to ask to go to another health centre. The mandatory requirement that pregnant women be tested for HIV does not necessarily promote women's decision-making or make it easier for women to act on their own, but it does remove the decision-making burden from women and remove men from weighing in on the decision to get tested.

[10] (See for example those of IntraHealth, and CARE and ICRW's Inner Spaces and Outer Faces initiative designed for development practitioners

[11] See for example EngenderHealth's Comprehensive Counselling for Reproductive Health: an Integrated Curriculum

The health system also can make it easier for women to assert their decision-making power over family health[12]. Women often are provided with health education simply because they tend to be the ones at homes or in the community when information activities take place. Some programmes, such as for childhood nutrition, target women in their role as mothers and being in charge of feeding the household. A weakness in these initiatives is assuming that having received information, women will act on it. As discussed below, women rarely have the resources and to do so independently; instead, they must first negotiate with their husbands to get needed permissions or resources.

However, women's ability to articulate the benefits of modern health care generally, or of specific interventions (such as sleeping under an insecticide-treated mosquito net), may be limited by their low levels of education and traditional gender norms that may intimidate them when they try to present the benefits to their husbands. Easy-to-understand pamphlets and other tools describing the benefits could help women communicate and thus bargain more effectively for these services. Such tools may be part of constructive male engagement approaches (discussed below) and could present treatment or interventions in a way that emphasises mutual gain and household benefit.

> If the wives had information materials illustrating the benefits of treatment and show support of their health goals by official or respected sources (such as the MOH and tribal leaders), then husbands might be more willing to agree to treatment.

5.2.4 Constructively engage men in support of women's and family health

Until the 1990s, development agencies and health promoters targeted women for specific health interventions, such as feeding their children more nutritious foods or using family planning, with the assumption that women could implement these interventions. This often was a false assumption – programmes came to recognise that women did not control the necessary resources or control decision making. Constructive male engagement approaches were largely developed in response to the failed interventions.

Constructive male engagement approaches promoted male buy-in to what were seen as women's health interventions (or "family health") with the intention of getting men and women to "partner" in developing common, rather than divergent, health goals, including promotion of women's and family health[13]. The goal of constructive male engagement is to get men's support for women's health interests, not to give men more control.

Constructive male engagement interventions extend health information to men and show men how they themselves, as fathers and members of the community benefit from these treatments or interventions. They encourage men to take a more proactive role in what were once seen as "women's issues" such as family planning, antenatal care, maternal health, nutrition and child care. Men are often targeted for participation in safe motherhood groups because they control the transportation to a facility delivery and make decisions regarding the terms of the delivery.

Implementing constructive male engagement approaches entails creating BCC materials and informational campaigns that target men and show them the benefits of specific health interventions, engage men on the community level to participate in child health and nutrition programmes and in activities related to safe motherhood, and convince tribal leaders and other opinion makers to encourage men to take a greater role in supporting women's and family health efforts. This also entails providing women with tools to help them justify their health goals to their husbands and get their support.

[12] The MOH's NHSP has made improving women's role in family health a priority

[13] See for example, the Men as Partners Initiative and EngenderHealth's Involving Men in Prevention of Mother-to-Child Transmission initiative.

On the health centre level, this approach entails making health centres more welcoming for men to attend with their children or wives, such as having family waiting rooms, special times for families to visit health centres and extended hours of operation so that it is easier for men to visit health centres. It may entail reorganising a centres' layout to provide space for couples counselling and ensuring that men can take their children in for treatment without imposing on the privacy of other female clients. It may also entail ensuring that health information in the health centre is designed for men so men do not feel they are invading on "women's space".

Such an approach also demands that health care workers be trained to engage respectfully with men as partners in their wife's or children's health. If a man accompanies his wife, the health workers should not let them jump the line or assume he has sole authority in her health decisions. If they both take their child, workers should not insinuate that the woman is failing in her responsibilities as a mother. Health workers must understand that the goal of constructive male engagement is to inspire men to support women's health goals and to treat men and women as partners.

Programmes that take these approaches have the potential to enable women to fulfil their demand for public health services denied them by traditional gender norms. The programmes challenge these gender norms that suppress demand and allow space for men and couples to explore and exercise their own health goals.

5.3 Eliminate or minimise obstacles and costs to using services

5.3.1 Address gender norms that make it uncomfortable to use services

Women and youth are discouraged from using SRH services because they fear their husbands or parents would object based on gender norms that grant men control over women's sexuality and health decisions, that prohibit premarital sex and that discourage males from seeking services. Therefore, encouraging the uptake of services means changing gender and social norms.

More and more health systems are taking a transformative approach to promote service uptake. As discussed above, examples are BCC campaigns that promote women's health decision-making or make it acceptable for men to seek treatment, working with men and women to challenge traditional stereotypes and the notion that men control women's sexuality and efforts to empower women. Other activities include working with parents or schools and adolescents to promote acceptance of and respect for adolescents' sexuality. Such activities can go a long way to addressing the underlying gender norms that present obstacles.

However, whilst it is necessary to challenge gender and social norms in order to have lasting impact, the health system can mean whilst make accommodative changes that limit patients' exposure to male or parental authority and make it more comfortable for patients to use services, that is, to make service delivery more gender-sensitive and user-friendly. Efforts to make the health facilities more "male-friendly" were discussed earlier (5.2.1), so the discussion here will focus on efforts to make facilities more women- and youth-friendly.

5.3.2 Make health services more gender-friendly

Efforts to make health services more gender-sensitive or gender- or youth-friendly accommodate realities. They recognise that men, women and youth start their treatment-seeking from different places and face different obstacles and costs. Activities do not seek to fundamentally change societal norms that discourage service seeking – they acknowledge the obstacles and help clients avoid or navigate around them.

The Zambian MOH has adopted this approach as articulated in the NHSP 2011-2015. For example, there is a commitment to "Make all currently female focused health services including participation in family health, more make (user) friendly" (70) and a commitment to "increase the participation of women in family health". Other examples are efforts to promote peer education and youth corners as part of the adolescent health programming.

5.3.3 Make services more accessible

Efforts to make health services more user-friendly often entail activities that locate health services closer to men, women and youth. For example, women-friendly services bring services to the village, markets and church groups. Youth-friendly services might locate in schools or youth clubs. Efforts to engage men in health promotion may distribute health information at sporting events or take health services to the fields or workplaces.

Women's ability to act on their own health goals is inhibited by their inability to mobilise resources and access services without their husband's support. Therefore, policies, programmes and protocols that support women's access enable women to access these resources on their own – for example, assisting with transportation to a health facility and a woman companion or advocate at the facility – will eliminate the need for women to ask their husbands for support. The presence of these health advocates improves women's comfort level in using services and compensates for some women's lack of "street smarts" that inhibit them from traveling long distances to seek care. Health advocates also facilitate patient-provider communication, which, in turn, promotes more accurate diagnosis, adherence to treatment and good health outcomes.

> Policies, programmes and protocols that support women's access include travel vouchers or the transportation itself, as well as treatment companions or women's health advocates who accompany women to the facility and support them through treatment.

Alternative payment schemes that eliminate women's need to ask their husbands for money also may help women feel they can make health decisions on their own. Payment schemes that offer lower fees for married women, the ability to pay back fees over longer periods of time or deferred payment may make it more manageable for women to repay without having to ask for the financial support of disapproving men.

Having health centres open before and after school hours might make it easier for youth to use them. Similarly, having designated service hours for youth, women and men may encourage each group to use services. In the FGDs, both men and adolescent men said that they would be more apt to use public health services if there were specific men's hours. Youth also spoke of the desire to have youth-only services.

Youth in the FGDs also suggested that STI and family planning services could be integrated into other health services so that adolescents would not have to risk the embarrassment of people knowing they were seeking services indicating they are sexually active. Similarly, providing a full range of family planning and STI (including HIV) services as part of antenatal care has proven to be effective in allowing women to access these services in a way that avoids them having to seek their husbands' permission. Likewise, the mandatory testing of pregnant women for HIV has taken the decision to get tested out of men's hands.

Taking steps to minimise exposure such as having proper signage, separate waiting rooms for men and women, and curtains for privacy are also components of a gender-sensitive facility, as are having private intake rooms so that clients need not disclose their reason for seeking treatment or health concerns in front of other people. A health centre that has a preponderance of BCC and other information materials targeted to women can also give the impression that men are not the intended end users of the centre; a gender-sensitive facility would have gender specific materials or a mix of materials so that men, women and youth would feel they were legitimate clients. In one of the health centres the team visited, health planners mentioned that the lack of toilets for women discouraged women from using the centres effectively. The absence of such necessary amenities sends a clear message and functions to marginalise specific groups (in this case women) from feeling entitled to use services.

Gender-sensitive health centres also have services or protocols that are sensitive to men's and women's social roles. They allow women to take their children into the facility with them, allow youth to receive treatment without parental permission and post announcements reminding patients of their right to privacy and confidentiality. Such health centres may also have particular services such as in-house health advocates or health companions to assist female clients within the health centre or to accompanying women if they are referred elsewhere.

In addition, gender-sensitive health centres also have providers with a skills mix to treat common health concerns for both men and women and corresponding drugs available. So for example, family planning methods and services that allow women to control and use family planning without them being detected would be available.

Perhaps most importantly, gender-sensitive facilities have trained staff who are sensitive to the realities in which men and women live. The workers are trained to recognise and counter traditional gender norms that result in negative health outcomes. At a minimum, staff should be trained not to allow their perceptions of appropriate behaviour influence their professional behaviour[14]. Ideally, staff understand the rationale behind approaches to women's decision-making, gender equality, constructive male engagement and efforts to promote men's health-seeking behaviour and be able to implement these approaches.

Health care providers should also be trained to feel comfortable engaging with men, to promote couples' communication and to provide couple's counselling. They should understand the need for privacy and confidentiality.

This requires reviewing and revising existing and forthcoming training packages to assure they reflect relevant approaches and principles. Expectations and directives regarding the rollout of these approaches should be written into job descriptions, support supervision and mentoring programmes and could be considered in staff advancement and promotion criteria. Staff behaviour and how it affects quality of care also should be introduced and examined and investigated in quality improvement efforts.

5.3.4 Create a gender balance within the health workforce

One component of gender-friendly and youth-friendly services is having same-sex and same-age health workers. Adolescents in the FGDs expressed appreciation for the peer counselling and peer education programmes that are currently in place. They also reported that they would be much more willing to use health services staffed by younger health workers who are aware of the special considerations of young people.

Whilst there does not appear to be hard data to demonstrate that the lack of female clinicians or male nurses has a negative impact on the uptake of health services in Zambia, FGD responses suggest that both men and women would feel more comfortable interacting with same-sex providers. There is also anecdotal evidence to suggest that men may be more willing to "allow" their wives to go to health centres or give birth at health centres if they were sure that their wives would be seen by female doctors and other providers.

The availability of same-sex providers is also likely to improve the quality of patient-client interaction, which in turn would improve quality of diagnosis and treatment, as well as adherence. Proper treatment, in turn, would increase the likelihood of improved health service uptake over the long run.

Resolving the human resources for health "crisis" was a major focus of the 2006-2010 NHSP. However, there is less mention of it in the 2011-2015 plan. The Ministry of Education, Science, Vocational Training and Early Education has made great strides in creating a gender balance within teaching and administrative positions. The MOH has made similar efforts, but has encountered formidable obstacles in deploying and retaining female doctors, especially in rural facilities. To address this, efforts should be made to collect gender data in the MOH Human Resource Information

[14] See, for example, IntraHealth's work and CARE's activities designed to help health workers identify their own gender biases

System and to identify the gender-based concerns that make it difficult to retain and deploy female health workers. PMOs and DCMOs, together with female health workers and planners, can work together to develop creative incentive packages to overcome these challenges and appropriate adjustments could be made in the Zambia Health Workers Retention Scheme.

5.3.5 Promote women's meaningful participation in health planning

When issues of health worker behaviour, same-sex providers and constructive male engagement have been addressed, making health centres more accessible for men and women is often a relatively easy and low-cost way to promote service uptake. Addressing the secondary gender-based constraints is often simply a question of identifying the particular deterrents or needs within the local community and making relatively small changes to address them. For example, lack of privacy can be handled by providing curtains, adjusting the locale of specific treatments or having separate hours for men and women. In one FGD, the team learned that a Neighbourhood Health Committee discovered that women were uncomfortable at the health centre because it had no toilets for women. The committee addressed this problem by securing funds to build women's toilet facilities at the health centre.

It is thus important for the health planners to accurately identify obstacles and work with clients to develop workable solutions to the obstacles. Directives that require health centre staff to develop interactive and constant feedback mechanisms (beyond a suggestion box) that enable clients to give their input and health centre staff to make adjustments accordingly have been implemented in a number of settings. A popular means to get this input is to engage community members in health planning at the local level.

As discussed in the Introduction, Zambia has a sophisticated health planning process that is designed to maximise citizen input at the local level. The NHSP 2011-2015 says it should "establish a data bank and carry out reviews to provide gender-relevant information for planning, decision making and balancing of sex representations in the health boards" (5). Whilst there is considerable representation of women in the Neighbourhood Health Committees, their representation declines at the higher levels. It is also important to note that women's representation in the leadership of these committees (a requisite for participation at high levels) is roughly half that of men's (ZISSP, 2012).

Best practice approaches for encouraging women's meaningful participation in health planning include working with communities to help them understand the role and function of the planning committees and the value of having women's participation in the health planning process. Other efforts have focused on helping communities challenge the traditional notions that "men's leadership skills" are better suited to leadership positions than are skills traditionally associated with women, such as problem solving and consensus building. Likewise, efforts to help communities recognise and value women's leadership skills have also been used to promote more gender-balanced planning committees.

Other efforts to promote women's meaningful participation in health planning have included building the capacity of women on the health planning committees to conduct priority-setting meetings with their constituency, to identify and advance issues that are important to women, and to advocate effectively within the health planning process. There also have been efforts to make the health planning process more gender-sensitive and inclusive of women. Such efforts have focused on creating opportunities for more community input and conducting stakeholder engagements with women's groups[15]. Other efforts have included building the capacity of health planners to facilitate meetings and stakeholder engagement in such a way that optimised women's input. Checklists or guidelines have also been used to help health planners locate women and design meetings in such a way that makes it more likely women will attend and participate in a meaningful way. Quotas or "reserved seats" for women on these committees have also been used to promote more representation of women in the process. In Nepal, there are also reserved seats for youth in the health planning process at the local level.

[15] See RTI's LEAD and TSHIP projects in Northern Nigeria

The MOH action planning guides provide a road map of the health planning process. They should be reviewed to ensure that they contain membership criteria that might include women and that they optimise opportunities to encourage women's input.

5.4 Improve the perceived benefits of using health services

Promoting the uptake of health services also depends on improving the benefits that clients think they will get from using health services. Section 4.0 discussed some of the ways in which gender norms and practices that exist outside the health centre are reinforced within the health centre and result in negative health outcomes. As mentioned, the impact of many of these gender norms on health outcomes goes unnoticed because they are presumed to be the natural order of things; that is, they are so embedded in our culture that we do not see them as something that can be changed. Whilst many of the concerns discussed in Section 4.0 have not be been identified as priorities that Zambia should address at this time, the fact that many other locations in the world have identified them as having negative consequences for health outcomes suggests that their impact on health outcomes in Zambia should at least be investigated.

In addition to discussing how gender can impact the accessibility and acceptability of public health services, Section 4.0 outlined how gender norms are likely to result in negative health outcomes. Therefore, challenging these gender norms, or at least ensuring that they are not reinforced within the facility, will be an important step towards improving health outcomes and therefore the perceived benefits of using health services.

5.4.1 Addressing gender norms that result in negative health outcomes outside the facility

Addressing gender norms that have negative health outcomes requires both transformative and accommodative activities. That is, there is a need for activities that challenge the many gender norms that cause patients to delay treatment seeking. These activities include BCC campaigns and interactive community-based programmes (such as Raising Voices in Uganda) designed to challenge the perception that male treatment-seeking is a sign of weakness or the notion that men control women's sexuality or have decision-making authority over women's health, or those that discourage premarital sex. Such initiatives will facilitate the public health facility's ability to deliver successful outcomes.

5.4.2 Addressing gender norms that result in negative health outcomes inside the facility

As was demonstrated in the discussion of benefits in Section 4.3, there are a number of ways in which gender norms are reinforced within the health facility and are likely to result in negative health outcomes. So, whilst transformative activities are needed to challenge gender norms that occur outside the health centre, how gender norms are reinforced within the health centre and their impacts on health outcomes should be investigated.

Gender norms are usually institutionalised in the facility through the behaviour of health workers, operational protocols and treatment procedures. They are manifested when a health worker allows groups accompanied by men to jump the queue and be seen before clients with more urgent medical needs; when a health worker fails to recognise the gender-based constraints to which women are subject and prescribes treatment that women cannot follow; or when a health worker rushes a male client out of the health centre without engaging him in conversation about some of his other health concerns. All of these actions can compromise health outcomes.

The notion that men delay seeking treatment and arrive at health centres with advanced symptoms was brought to light in the FGDs and is confirmed by anecdotal evidence in the literature. It appears that this is a well-accepted phenomenon that is attributed to "culture". Yet, like the lack of women's health decision-making, it can have serious consequences for public health outcomes. Health facilities could be encouraged to identify incidence of delayed treatment seeking amongst men and to

systematically consider its consequences in clinical care and quality improvement processes. If it is determined to be a "problem", then there are a number of different ways it can be addressed at the community and facility level.

Given the potential for gender norms to result in negative health outcomes, it is worthwhile to bring them into the purview of investigation in quality improvement and clinical care supervision processes. Numerous efforts are now being made to "genderise" quality improvement processes[16]. Most include building the capacity of health workers to identify how gender norms can compromise health outcomes and, when this does occur, they facilitate discussions and processes in which health workers can critically explore the impact on health outcomes and identify ways to make positive changes. To date, most of these efforts have been small scale and focused on helping health workers look critically at the way their work is performed and start to recognise where positive changes can be made.

[16] See for example URC's activities and WiHER

6. Conclusion

Gender is constructed in a way that accords men and women different knowledge, access to resources and decision-making power. These differences impact the demand men and women have for health services and their ability to act on that demand. As a result of these differences, men and women face different obstacles and challenges when they seek to use health services. These differences are also likely to affect how men and women are likely to be treated in the clinic, how they feel about the services they receive and how likely they are to use public health services in the future. Improving the uptake of public health services will require that health planners take these differences into consideration.

As such, promoting the uptake of health services from a health system strengthening perspective requires health planners to expand their range of activities and proactively tackle the traditional gender norms and societal attitudes that make men and women feel they do not need or want specific services. Efforts to improve the uptake of public health services will also require that health planners identify and constructively transform the gender-based constraints that create challenges and obstacles for men and women to use health services once demand has been established.

However, changing attitudes and gender norms is not done quickly. Therefore, while active measures to address the attitudes that give rise to these obstacles are needed, the health system must also help clients work around these gender-based constraints and adjust the way in which it provides services so as to minimise the challenges and potential costs of using health services. It must take active measures to adjust services to make them more accessible and acceptable to men and women.

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